FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032680

Facility Name: Rosewood Care Center-Swansea

Address: 100 Rosewood Village Drive (Number) Swansea (City) 62222 (Zip Code)

County: St. Clair

Telephone Number: (618) 236-1391 **Fax #** ( )

IDPA ID Number: 431375409001

Date of Initial License for Current Owners: 10/08/87

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller **Telephone Number:** (618) 465-7717

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/1999 to 06/30/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) See Accountants' Compilation Report (Date)
(Print Name and Title) Cindy A. Tefteller
(Firm Name & Address) C.J. Schlosser & Company, L.L.C.
233 East Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax (618) 465-7710

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Print Previe

Facility Name & ID Number Rosewood Care Center-Swansea # 0032680 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,920	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,920	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			3,633	3,633	8
9	SNF/PED					9
10	ICF	2,480	32,106		34,586	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,480	32,106	3,633	38,219	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4) 87.02%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/08/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/08/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 30 and days of care provided 3633

Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/2000 Fiscal Year: 06/30/2000

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Previe

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Rosewood Care Center-Swansea # 0032680 **Report Period Beginning:** 07/01/1999 **Ending:** 06/30/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	176,399	16,951	8,190	201,540		201,540	0	201,540			1
2	Food Purchase		176,936		176,936		176,936	(9,963)	166,973			2
3	Housekeeping	107,644	29,160		136,804		136,804	0	136,804			3
4	Laundry	36,184	21,327		57,511		57,511	0	57,511			4
5	Heat and Other Utilities			107,715	107,715		107,715	0	107,715			5
6	Maintenance	18,442	11,812	55,515	85,769		85,769	3,487	89,256			6
7	Other (specify): Sanitation			24,128	24,128		24,128	0	24,128			7
8	**TOTAL General Services**	338,669	256,186	195,548	790,403		790,403	(6,476)	783,927			8
	B. Health Care and Programs											
9	Medical Director			10,000	10,000		10,000	0	10,000			9
10	Nursing and Medical Records	1,410,082	177,519	1,328	1,588,929		1,588,929	0	1,588,929			10
10a	Therapy	62,701	1,221	199,721	263,643		263,643	66,903	330,546			10a
11	Activities	41,564	6,135	2,647	50,346		50,346	0	50,346			11
12	Social Services	35,737		2,636	38,373		38,373	0	38,373			12
13	Nurse Aide Training							0				13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16	**TOTAL Health Care and Progra**	1,550,084	184,875	216,332	1,951,291		1,951,291	66,903	2,018,194			16
	C. General Administration											
17	Administrative			618,554	618,554		618,554	(516,788)	101,766			17
18	Directors Fees							0				18
19	Professional Services			4,923	4,923		4,923	55,362	60,285			19
20	Dues, Fees, Subscriptions & Promotions			19,546	19,546		19,546	(9,947)	9,599			20
21	Clerical & General Office Expense	106,849	20,419	23,522	150,790		150,790	197,252	348,042			21
22	Employee Benefits & Payroll Taxes			269,592	269,592		269,592	29,034	298,626			22
23	Inservice Training & Education							0				23
24	Travel and Seminar			1,919	1,919		1,919	0	1,919			24
25	Other Admin. Staff Transportation			4,333	4,333		4,333	10,859	15,192			25
26	Insurance-Prop.Liab.Malpractice			28,915	28,915		28,915	3,835	32,750			26
27	Other (specify):*							0				27
28	**TOTAL General Administration**	106,849	20,419	971,304	1,098,572		1,098,572	(230,393)	868,179			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,995,602	461,480	1,383,184	3,840,266		3,840,266	(169,966)	3,670,300			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000. SEE ACCOUNTANTS' COMPILATION REPORT**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Previe

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Rosewood Care Center-Swansea # 0032680 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			22,324	22,324		22,324	167,912	190,236			30
31	Amortization of Pre-Op. & Org.							9,444	9,444			31
32	Interest			63,941	63,941		63,941	603,414	667,355			32
33	Real Estate Taxes			68,344	68,344		68,344	0	68,344			33
34	Rent-Facility & Grounds			1,237,345	1,237,345		1,237,345	(1,226,724)	10,621			34
35	Rent-Equipment & Vehicles							0				35
36	Other (specify):*							0				36
37	TOTAL Ownership			1,391,954	1,391,954		1,391,954	(445,954)	946,000			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		69,002	17,240	86,242		86,242	(2,188)	84,054			39
40	Barber and Beauty Shops			19,265	19,265		19,265	0	19,265			40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			65,880	65,880		65,880	0	65,880			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		69,002	102,385	171,387		171,387	(2,188)	169,199			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,995,602	530,482	2,877,523	5,403,607	0	5,403,607	(618,108)	4,785,499			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Previe

SEE ACCOUNTANTS' COMPILATION REPORT

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number Rosewood Care Center-Swansea # 0032680 Report Period Beginning: 07/01/1999 Ending: 6/30/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,236)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(2,188)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(727)	2		13
14	Non-Care Related Interest	(63,941)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,000)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,491)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,456)	20		28
29	Other-Attach Schedule Marketing Salary	(28,885)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (114,924)		$	30

OHF USE ONLY								
48		49		50		51	52	

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(503,184)	Var	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (503,184)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (618,108)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Print Previe

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.
The amounts in columns F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.
1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other Adjustments

STATE OF ILLINOIS **Page 5A**

Facility Name Rosewood Care Center-Swansea
IDPH 0022680
Report Period Beginning: 07/01/1999
Ending: 06/30/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
The information listed in B13 thru G43 is from Page 5.				**Line 1**	0
1	**Day Care**	0	0	**Line 2**	(9,982)
2	**Other Cars for Outpatients**	0	0	**Line 3**	0
3	**Governmental Sponsored Special Programs**	0	0	**Line 4**	0
4	**Non-Patient Meals**	(9,236)	2	**Line 5**	0
5	**Telephone, TV & Radio in Resident Rooms**	0	0	**Line 6**	0
6	**Rented Facility Space**	0	0	**Line 7**	0
7	**Sale of Supplies to Non-Patients**	0	0	**Line 8**	(9,982)
8	**Laundry for Non-Patients**	0	0	**Line 9**	0
9	**Non-Straightline Depreciation**	0	0	**Line 10**	0
10	**Interest and Other Investment Income**	0	0	**Line 10a**	0
11	**Discounts, Allowances, Rebates & Refunds**	(2,188)	39	**Line 11**	0
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 12**	0
13	**Sales Tax**	(727)	2	**Line 13**	0
14	**Non-Care Related Interest**	(63,941)	32	**Line 14**	0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 15**	0
16	**Personal Expenses (Including Transportation)**	0	0	**Line 16**	0
17	**Non-Care Related Fees**	(3,000)	20	**Line 17**	0
18	**Fines and Penalties**	0	0	**Line 18**	0
19	**Entertainment**	0	0	**Line 19**	0
20	**Contributions**	0	0	**Line 20**	(9,341)
21	**Owner or Key-Man Insurance**	0	0	**Line 21**	(29,835)
22	**Special Legal Fees & Legal Retainers**	0	0	**Line 22**	0
23	**Malpractice Insurance for Individuals**	0	0	**Line 23**	0
24	**Bad Debt**	0	0	**Line 24**	0
25	**Fund Raising, Advertising and Promotional**	(2,491)	20	**Line 25**	0
26	**Income & IL Personal Property Replacement T**	0	0	**Line 26**	0
27	**Nurse Aide Training for Non-Employees**	0	0	**Line 27**	0
28	**Yellow Page Advertising**	(4,456)	20	**Line 28**	(38,870)
29	**Non-Paid Workers**	0	0	**Line 29**	(48,709)
30	**Donated Goods**	0	0	**Line 30**	0
31	**Amortization Expense**	0	0	**Line 31**	0
32	Eliminate Marketing Salary	(29,885)	21	**Line 32**	(63,941)
33				**Line 33**	0
34				**Line 34**	0
35				**Line 35**	0
36				**Line 36**	0
37				**Line 37**	(63,941)
38				**Line 38**	0
39				**Line 39**	(2,188)
40				**Line 40**	0
41				**Line 41**	0
42				**Line 42**	0
43				**Line 43**	0
44				**Line 44**	(2,188)
45				**Line 45**	(114,959)

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb Rosewood Care Center-Swansea # 0032680 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,963)	0	0	0	0	0	0	0	0	0	0	(9,963)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	3,487	0	0	0	0	0	0	0	0	3,487	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(9,963)	0	3,487	0	0	0	0	0	0	0	0	(6,476)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	66,903	0	0	0	0	0	0	0	0	0	66,903	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	0	66,903	0	0	0	0	0	0	0	0	0	66,903	16
	C. General Administration													
17	Administrative	0	(598,554)	81,766	0	0	0	0	0	0	0	0	(516,788)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,512	53,850	0	0	0	0	0	0	0	0	55,362	19
20	Fees, Subscriptions & Promotions	(9,947)	0	0	0	0	0	0	0	0	0	0	(9,947)	20
21	Clerical & General Office Expenses	(28,885)	154	225,983	0	0	0	0	0	0	0	0	197,252	21
22	Employee Benefits & Payroll Taxes	0	290	28,744	0	0	0	0	0	0	0	0	29,034	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	10,859	0	0	0	0	0	0	0	0	10,859	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,835	0	0	0	0	0	0	0	0	3,835	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(38,832)	(596,598)	405,037	0	0	0	0	0	0	0	0	(230,393)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(48,795)	(529,695)	408,524	0	0	0	0	0	0	0	0	(169,966)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: Rosewood Care Center-Swansea # 0032680 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	147,335	20,577	0	0	0	0	0	0	0	0	167,912	30
31	Amortization of Pre-Op. & Org.	0	9,444	0	0	0	0	0	0	0	0	0	9,444	31
32	Interest	(63,941)	667,355	0	0	0	0	0	0	0	0	0	603,414	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	########	10,621	0	0	0	0	0	0	0	0	(1,226,724)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(63,941)	(413,211)	31,198	0	0	0	0	0	0	0	0	(445,954)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(2,188)	0	0	0	0	0	0	0	0	0	0	(2,188)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Cent	(2,188)	0	0	0	0	0	0	0	0	0	0	(2,188)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(114,924)	(942,906)	439,722	0	0	0	0	0	0	0	0	(618,108)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE ACCOUNTANTS' COMPILATION REPORT

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe Rosewood Care Center-Swansea # 0023680 Report Period Beginning 07/01/1999 Ending: 06/30/2000

Show Pgs 6A thru 6 | Show Pgs 6E thru 6 | Hide Pgs 6A thru 6

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Larry Vander Maten	75.00%	See Attached List		See Attached List		
Darrell Herring	25.00%	See Attached List		See Attached List		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6
1	V	17 Management Fee	$ 618,554	HSM Management Services, Inc	100.00%	$	$ (618,554)	1	-618554
2	V							2	
3	V	10a Therapy	199,721	Rosewood Therapy Services, Inc	0.00%	266,624	66,903	3	66903
4	V							4	
5	V	34 Rent	1,237,345	Swansea Real Estate Co., Inc.	0.00%		(1,237,345)	5	-1237345
6	V	20 Depreciation		Swansea Real Estate Co., Inc.		147,335	147,335	6	147335
7	V	22 Interest		Swansea Real Estate Co., Inc.		667,355	667,355	7	667355
8	V	21 Amortization - Loan Fees		Swansea Real Estate Co., Inc.		9,444	9,444	8	9444
9	V	17 Owners' Compensation		Swansea Real Estate Co., Inc.		20,000	20,000	9	20000
10	V	21 Office Expense		Swansea Real Estate Co., Inc.		154	154	10	154
11	V	22 Payroll Taxes		Swansea Real Estate Co., Inc.		290	290	11	290
12	V	35 Professional Fees		Swansea Real Estate Co., Inc.		1,512	1,512	12	1512
13	V							13	
14	Total		$ 2,055,620			$ 1,112,714	$ * (942,906)	14	

* Total must agree with the amount recorded on line 34 of Schedule V SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

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SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number Rosewood Care Center-Swansea # 0032680 Report Period Beginnin 07/01/1999 Ending: 06/30/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	17	See Schedule VIII	$	HSM Management Services, Inc.	100.00%	$ 81,766	$ 81,766	15	81766
16	V	21	See Schedule VIII		HSM Management Services, Inc.	100.00%	225,983	225,983	16	225983
17	V	22	See Schedule VIII		HSM Management Services, Inc.	100.00%	28,744	28,744	17	28744
18	V	25	See Schedule VIII		HSM Management Services, Inc.	100.00%	10,859	10,859	18	10859
19	V	30	See Schedule VIII		HSM Management Services, Inc.	100.00%	20,577	20,577	19	20577
20	V	34	See Schedule VIII		HSM Management Services, Inc.	100.00%	10,621	10,621	20	10621
21	V	19	See Schedule VIII		HSM Management Services, Inc.	100.00%	53,850	53,850	21	53850
22	V	26	See Schedule VIII		HSM Management Services, Inc.	100.00%	3,835	3,835	22	3835
23	V	6	See Schedule VIII		HSM Management Services, Inc.	100.00%	3,487	3,487	23	3487
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$			$ 439,722	$ * 439,722	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.** **SEE ACCOUNTANTS' COMPILATION REPORT**

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number Rosewood Care Center-Swansea # 0032680 Report Period Beginnin 07/01/1999 Ending: 06/30/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

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Print Page 6

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STATE OF ILLINOIS

Facility Name & ID Number Rosewood Care Center-Swansea # 0032680 Report Period Beginnin 07/01/1999 Ending: 06/30/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6C

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

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Print Page 6

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STATE OF ILLINOIS

Facility Name & ID Number Rosewood Care Center-Swansea # 0032680 Report Period Beginnin 07/01/1999 Ending: 06/30/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Rosewood Care Center-Swansea # 0032680 Report Period Beginnin 07/01/1999 Ending: 06/30/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Larry Vander Maten	President	Management	75.00%	434,718	3	6.68%	Salary	$ 35,094	17-8	1
2	Darrell Hoefling	Vice-President	Management	25.00%	163,573	3	6.68%	Salary	7,698	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 42,792		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

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the name(s)
PORTS.

Facility Name & ID Number Rosewood Care Center-Swansea # 0032680 Report Period Beginning: 07/01/1999 Ending: 6/30/2000

VIII. ALLOCATION OF INDIRECT C

Show Pgs 8A thru 8 | Show Pgs 8E thru 8 | Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: HSM Management Services, Inc.
Street Address: 11701 Borman Drive, Suite 315
City / State / Zip Code: St. Louis, MO 63146
Phone Number: (314) 994-9070
Fax Number: (314) 994-9912

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries - Officers	Total Cost	63,328,031	17	$ 341,083	$ 341,083	4,231,773	$ 22,792	1
2	21	Salaries - Other	Total Cost	63,328,031	17	2,916,125	2,916,125	4,231,773	194,864	2
3	22	Payroll Taxes	Total Cost	63,328,031	17	221,266		4,231,773	14,786	3
4	22	Employee Benefits	Total Cost	63,328,031	17	87,376		4,231,773	5,839	4
5	25	Travel	Total Cost	63,328,031	17	123,502		4,231,773	8,253	5
6	30	Depreciation	Total Cost	63,328,031	17	273,812		4,231,773	18,297	6
7	34	Building Rent	Total Cost	63,328,031	17	158,940		4,231,773	10,621	7
8	19	Professional Services	Total Cost	63,328,031	17	805,860		4,231,773	53,850	8
9	21	Telephone	Total Cost	63,328,031	17	167,133		4,231,773	11,168	9
10	26	Insurance	Total Cost	63,328,031	17	57,385		4,231,773	3,835	10
11	21	Taxes & Licenses	Total Cost	63,328,031	17	7,008		4,231,773	468	11
12	21	Office Supplies	Total Cost	63,328,031	17	291,559		4,231,773	19,483	12
13	6	Maintenance	Total Cost	63,328,031	17	46,996		4,231,773	3,140	13
14	17	Direct - Admin Salaries	Direct Cost	1	1	58,974	58,974	1	58,974	14
15	17	Direct - Admin Salaries	Direct Cost	16	16	909,579	909,579	0	0	15
16	22	Direct - Payroll Taxes	Direct Cost	1	1	8,119		1	8,119	16
17	22	Direct - Payroll Taxes	Direct Cost	16	16	90,058		0	0	17
18	30	Direct - Depreciation	Direct Cost	1	1	2,280		1	2,280	18
19	30	Direct - Depreciation	Direct Cost	16	16	30,230		0	0	19
20	25	Direct - Travel	Direct Cost	1	1	2,606		1	2,606	20
21	25	Direct - Travel	Direct Cost	16	16	231,193		0	0	21
22	6	Direct - Maintenance	Direct Cost	1	1	347		1	347	22
23	6	Direct - Maintenance	Direct Cost	16	16	8,082		0	0	23
24										24
25	TOTALS					$ 6,839,513	$ 4,225,761		$ 439,722	25

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Rosewood Care Center-Swansea # 0032680 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bonds		X		Varies	10/21/93	$ 5,500,000	$ 0	N/A	7.25%	$ 74,386	1
2	Bank of America		X	Loan Refinancing	$85,143.00	10/26/99	10,237,500	10,178,648	11/2009	8.89%	625,210	2
3	Less: Related Party Interest Offset										(32,241)	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$85,143.00		$ 15,737,500	$ 10,178,648			$ 667,355	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 15,737,500	$ 10,178,648			$ 667,355	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Numbe Rosewood Care Center-Swansea # 0032680 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	69,200	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	68,344	2
3. Under or (over) accrual (line 2 minus line 1).	$	(856)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	69,200	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	68,344	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	73,927	8
	1996	72,371	9
	1997	66,068	10
	1998	68,282	11
	1999	68,407	12

1998 Payment $34,140
1999 Payment $34,204
Accrual = Balance of 1999 Tax Bill (34,204) + 1/2 of estimated 2000 Tax Bill (34,996)

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Numb Rosewood Care Center-Swansea # 0032680 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,331 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 245,650
2. Number of Years Over Which it is Being Amortized: Bond Fees-20 Yrs; Other-60 Mos.
3. Current Period Amortization: 9,444
4. Dates Incurred: Bonds Issued October 1993

Nature of Costs: Bond Fees - $241,750; Org. Costs - $1,678; Trustee Fees - $2,222

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	6.8097 Acres	1987	$ 126,031	1
2					2
3	TOTALS			$ 126,031	3

SEE ACCOUNTANTS' COMPILATION REPORT

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12 | Show Pgs 12C and 12 | Hide Pgs 12A thru 12

Facility Name & ID Number Rosewood Care Center-Swansea # 0032680 Report Period Beginning: 07/01/1995 Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120			1987	$ 2,175,969	$	20-25	$ 94,860	$ 94,860	$ 1,205,716	4
5				1988	253,539		25	10,142	10,142	118,323	5
6				1990	222,972		5-25	8,582	8,582	92,467	6
7				1991	6,679		25	267	267	2,336	7
8											8
	Improvement Type**										
9	Beam Water Hydrant			1988	1,677		10			1,677	9
10	Trees and Seeding			1988	745		10			745	10
11	Seeding			1988	4,290		10			4,290	11
12	End Parking Lot Expansion			1988	621		25	25	25	298	12
13	Landscaping			1989	1,904		25	76	76	874	13
14	Road			1990	431,970		25	17,279	17,279	172,790	14
15	Parking Lot Expansion			1989	27,592		15	1,839	1,839	20,535	15
16	Lawn Sprinkler System			1992	10,926		25	437	437	3,387	16
17	Backflow for Sprinkler			1993	2,909		25	116	116	831	17
18	Landscape/Fencing			1987	25,279		25	1,011	1,011	12,890	18
19	Sinks			1987	4,156		10			4,156	19
20	Walk-In Cooler			1987	5,515		10			5,515	20
21	Exhaust Hood			1987	6,498		10			6,498	21
22	Hand Sinks			1987	181		10			181	22
23	Paging System			1987	632		10			632	23
24	Carpet			1987	39,910		10			39,910	24
25	Hospital Track/Curtain			1987	8,075		10			8,075	25
26	Signs			1987	2,916		10			2,916	26
27	Telephone Equipment			1987	3,180		10			3,180	27
28	Outside Sign			1987	4,504		10			4,504	28
29	Water Heater			1988	3,650		10			3,650	29
30	Walk-In Freezer			1988	3,936		15	262	262	3,144	30
31	Nurse Call System			1989	670		15	45	45	510	31
32	Sign			1989	2,000		10			2,000	32
33	Exhaust Fan			1989	530		10			530	33
34											34
35	Continued on Next Page										35
36	TOTAL (lines 4 thru 35)				$ 3253425	$		$ 134,941	$ 134,941	$ 1,722,560	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Numbe Rosewood Care Center-Swansea # 0032680 Report Period Beginning: 07/01/1995 Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Water Treatment System			1989	5,905		10	94	94	5,905	9
10	Door Guards			1989	5,509		10	137	137	5,509	10
11	Corner Guards			1990	1,446		10	93	93	1,446	11
12	Carpeting			1990	2,215		10	222	222	2,201	12
13	Hot Water Storage Tank			1996	2,607		10	261	261	935	13
14											14
15	Leasehold Improvements - Facility:										15
16	Carpet/Tile/Painting-Nurse Call Station			1993	20,471	1,878	7	1,878		20,471	16
17	Painting/Wallpaper			1994	15,422	2,203	7	2,203		13,444	17
18	Painting/Wallpaper/Tile			1995	25,375	3,627	7	3,627		18,428	18
19	Shelving			1995	2,186	312	7	312		1,690	19
20	New Upholstery			1995	513	73	7	73		389	20
21	Design Work			1995	128	18	7	18		95	21
22	Carpeting			1996	5,580	797	7	797		3,520	22
23	Painting/Tiling			1996	6,383	912	7	912		3,323	23
24	Painting			1997	3,025	432	7	432		1,260	24
25	Tile & Base 2 Rooms			1997	1,400	200	7	200		583	25
26	2 Oak Doors			1997	803	115	7	115		326	26
27	Carpet and Installation			1998	7,951	1,136	7	1,136		2,745	27
28	Shower Renovations			1998	16,869	2,410	7	2,410		5,724	28
29	Paint/Wallpaper/Tile Removal			1998	1,833	262	7	262		574	29
30	Shower Room			1998	18,424	2,632	7	2,632		4,935	30
31	Wallpaper			1999	273	39	7	39		52	31
32	Painting			1998	970	139	7	139		301	32
33	Wallpaper			1998	5,103	729	7	729		1,519	33
34											34
35	Continued on Next Page										35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 17,914		$ 18,721	$ 807	$ 95,375	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe Rosewood Care Center-Swansea # 0032680 Report Period Beginning: 07/01/1995 Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Carpet/Installation			1998	5,106	729	7	729		1,519	9
10	Phone System			1998	8,703	1,243	7	1,243		2,336	10
11	Wallpaper			1998	4,450	636	7	636		1,234	11
12	Drapery			2000	31,964	1,802	7	1,802		1,802	12
13											13
14											14
15	Leasehold Improvements - Management Company										15
16	Office Construction / Improvements			1995	512		5	102	102	512	16
17	Office Design			1995	47		5	10	10	47	17
18	Office Shelving			1996	109		4	26	26	109	18
19	Office Expansion			1996	483		4	121	121	483	19
20	Office Expansion			1997	1,293		3	410	410	1,293	20
21	Office Expansion			1998	729		3	244	244	432	21
22	Office Addition			1999	360		3	120	120	120	22
23	Door Locks			1999	180		3	35	35	35	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 4,410		$ 5,478	$ 1,068	$ 9,922	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number Rosewood Care Center-Swansea # 0032680 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 236,888	$	$ 22,110	$ 22,110	5-7 Yrs	$ 146,941	37
38	Current Year Purchases	10,334		932	932	5-7 Yrs	932	38
39	Fully Depreciated Assets	388,329					388,329	39
40								40
41	TOTALS	$ 635,551	$	$ 23,042	$ 23,042		$ 536,202	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	HSM Management	Various	Various	$ 47,045	$	$ 8,054	$ 8,054	5 Yrs	$ 18,762	42
43										43
44										44
45										45
46	TOTALS			$ 47,045	$	$ 8,054	$ 8,054		$ 18,762	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 22,324	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 190,236	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 167,912	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,382,821	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Section Not Applicable	$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58	Section Not Applicable	$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

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XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease Schedule Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. _____
This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the curre
rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipm $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Rosewood Care Center-Swansea # 0032680 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

SCHEDULE NOT APPLICABLE - ONLY HIRE CERTIFIED AIDES

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Rosewood Care Center-Swansea # 0032680 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Cost	Outside Practitioner (other than consultant) Units		Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-8	hrs		$	5,328	$	63,773	$	5,328	$ 63,773	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs			1,737		29,239		1,737	29,239	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10a-8	hrs			10,688		173,612	1,221	10,688	174,833	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39-8	# of prescrpts						69,002		69,002	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Exceptional Care Program											12
13	X-Ray, Ambulance & Other (specify): Lab Fees	39-8						15,052			15,052	13
14	TOTAL				$	17,753	$	281,676	$ 70,223	17,753	$ 351,899	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Rosewood Care Center-Swansea # 0032680 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 468,569	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 7,000)	555,864		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,532		6
7	Other Prepaid Expenses	6,623		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Deferred Income Tax Benefit	4,000		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,047,588	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	182,932		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(86,270)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 96,662	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,144,250	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 193,199	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	141,619		29
30	Accrued Salaries Payable	170,398		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,819		31
32	Accrued Real Estate Taxes(Sch.IX-B)	69,200		32
33	Accrued Interest Payable	8,957		33
34	Deferred Compensation			34
35	Federal and State Income Taxes	28,000		35
	Other Current Liabilities(specify):			
36	Accrued Management Fees	371,715		36
37	Accrued Rent	45,776		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,042,683	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,042,683	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 101,567	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,144,250	$	48

SEE ACCOUNTANTS' COMPILATION REPORT ***(See instructions.)**

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Facility Name & ID Number Rosewood Care Center-Swansea # 0032680 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 90,893	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 90,893	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	166,274	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(155,600)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 10,674	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 101,567	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Rosewood Care Center-Swansea # 0032680 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,565,069	1
2	Discounts and Allowances for all Levels	(888,887)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,676,182	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	839,741	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 839,741	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	22,398	13
14	Non-Patient Meals	9,236	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$ 31,634	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	102,861	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 102,861	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Lab Discount**	2,188	28
28a	**Miscellaneous Income**	21,275	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 23,463	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 5,673,881	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 790,403	31
32	Health Care	1,951,291	32
33	General Administration	1,098,572	33
	B. Capital Expense		
34	Ownership	1,391,954	34
	C. Ancillary Expense		
35	Special Cost Centers	105,507	35
36	Provider Participation Fee	65,880	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,403,607	40
41	**Income before Income Taxes (line 30 minus line 40)****	270,274	41
42	**Income Taxes**	(104,000)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ 166,274	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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